

FILED OCT 25 1943
Registration District No. 149

Primary Registration District No. 1002

State File No. _____
Registrar's No. 4243

1. PLACE OF DEATH:

(a) County Kansas
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community 53 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2041 N. 32nd St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4
year 1943 hour 12:15PM minute _____ M.
21. I hereby certify that I attended the deceased from
Sept. 22 1943 to Oct 4 1943
that I last saw him alive on Oct 3 1943
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis Duration 11 Days
Due to Arterial Fibrillation
(Fibrillation) & Valvular Heart Disease ?
Due to _____
Other conditions
(Include pregnancy within 3 months of death)
831P

PHYSICIAN

Major findings:
Of operations _____
Of autopsy See above
Thrombosis of basilar artery, tubed etc
Underline the cause to which death should be charged state and city.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. E. Brown (M. D. or other) _____
Address 1002 Myrtle Ave Date signed Oct 6 43

3. (a) PRINT FULL NAME Joseph Cass
3. (b) If veteran, name war World War #1 3. (c) Social Security N702-14-0928

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ruth G. Cass 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased. February 14 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 7 20 hr. min.

9. Birthplace Kansas City Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk-Traffic Dept

11. Industry or business Missouri Pacific R.R.

MOTHER FATHER
12. Name John Cass
13. Birthplace England 4
(City, town, or county) (State or foreign country)
14. Maiden name Martina Allott
15. Birthplace England 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruth Cass
(b) Address 2041 N. 32nd St K.C. Kans

17. (a) Removal (b) Date thereof 10-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery KCK

18. (a) Signature of funeral director Geo. H. Long
(b) Address Kansas City Kansas

19. (a) 10-6-43 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 27 1947

*Dr. Lathrop
1002 1/2 1st St
S.E.*

EX-15-110

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Chas. H. Rider*
Licensed Embalmer No. *3404*
P. O. Address *703 N. 10th - 1st - 1st*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.